

**WISCONSIN MEDICAID
REQUEST FOR NURSING HOME CARE DETERMINATION**

Instructions: Type or print clearly. Before completing this form, read the Request for Nursing Home Care Determination Completion Instructions (HCF 1020A).

SECTION I — PROVIDER INFORMATION

Name — Billing Provider

Billing Provider's Medicaid Provider Number

National Provider Identifier

Address — Provider (Street, City, State, Zip Code)

Name — Nursing Home Contact Person

Telephone Number — Nursing Home Contact Person

SECTION II — RECIPIENT INFORMATION

Name — Recipient (Last, First, Middle Initial)

Recipient Medicaid Identification Number

Address — Recipient (If Different from Provider Address — Include Street, City, State, and Zip Code)

Social Security Number — Recipient

Date of Birth — Recipient

Gender — Recipient

☐ Male

☐ Female

Requested Payment Effective Date

Discharge Date

Minimum Data Set (MDS) Submittal

☐ Minimum data set submitted or will be submitted.

☐ No MDS will be submitted.

For cases where no MDS will be submitted, attach the physician's orders. List other attachments, as necessary.

SECTION III — BUREAU OF QUALITY ASSURANCE INFORMATION

Self-Reported Level of Care for Staffing Purposes

☐ ISN

☐ SNF

☐ ICF-1

☐ ICF-2

☐ DD1a

☐ DD1b

☐ DD2

☐ DD3